



DEPARTMENT OF THE NAVY

NAVAL DENTAL CENTER

2310 CRAVEN ST.

BOX 368147

SAN DIEGO, CALIFORNIA 92136-5596

NAVDENCENS DIEGO INST 6600.10C

00Q

06 MAY 98

NAVDENCENTER SAN DIEGO INSTRUCTION 6600.10C

Subj: INFECTION CONTROL PROGRAM

Ref: (a) BUMEDINST 6600.10A

Encl: (1) Naval Dental Center, San Diego (NDCSD), Infection Control Manual

1. Purpose. To provide policy, prescribe procedures, and assign responsibility for proper infection control practices at the Naval Dental Center, San Diego.

2. Cancellation. NAVDENCENS DIEGO INST 6600.10B.

3. Policy. It is the policy of Naval Dental Center, San Diego that Infection Control Programs and procedures be performed in strict compliance with reference (a). Infection control in dentistry will receive a high priority at this Command. The safety and well-being of patients and staff is a primary responsibility of all personnel. Therefore, infection control is an integral part of the Quality Assurance Program.

4. Responsibility. The Infection Control Officer is tasked with overall development, interperation, implementation, and management of the Infection Control Program at Naval Dental Center, San Diego. It is the responsibility of each member of this command to become aware of and practice proper infection control procedures as outlined in reference (a) and enclosure (1).

5. Action. Reference (a) and enclosure (1) establish universal protocols of infection control that will be followed by all personnel at Naval Dental Center, San Diego. Initial infection control training of all newly reporting staff members will be done prior to performing any direct patient care or ancillary functions to patient care. Form NDCSD 6600/10-4 (Rev 11-92) will be read and signed after this training. Occupational Safety and Health Administration (OSHA) rules on occupational exposures to blood-borne pathogens, 29 CFR 1910.1030 will be made available to all personnel.

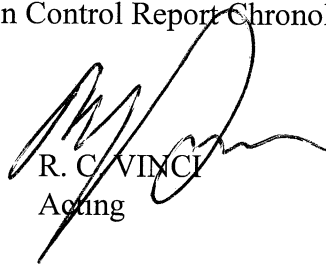
6. Forms. The forms required by this instruction will be obtained by local reproduction, with the exception of NDCSD 5102/2 (2-19), Supervisor's Mishap Report which will be obtained from NDCSD Materiel Management Department. Forms NDCSD 6600/10-1 (Rev 11-92); General DOR Infection Control Checklist NDCSD 6600/10-2 (Rev 11-92); CSR Infection Control Checklist NDCSD 6600/10-3 (Rev 11-92), Dental Lab Infection Control Checklist found in enclosure (1).



NAVDENCENS DIEGO INST 6600.10C

The required forms are:

- a. NDCSD 5102/2 (2-91), Supervisor's Mishap Report.
- b. NDCSD 6600/10-1 (Rev 11-92), General DOR Infection Control Checklist.
- c. NDCSD 6600/10-2 (Rev 11-92), CSR Infection Control Checklist.
- d. NDCSD 6600/10-3 (Rev 11-92), Dental Lab Infection Control Checklist.
- e. NDCSD 6600/10-4 (Rev 11-92), Command Infection Control Policies For New Staff Members.
- f. NDCSD 6600/10 (8-91), Infection Control Report Chronology of Treatment.


R. C. VINCE
Acting

Dist:
List 1, Case 1,2

INFECTION CONTROL MANUAL
NAVAL DENTAL CENTER, SAN DIEGO

Enclosure (1)

CONTENTS

Chapter 1 GENERAL INFORMATION

Page

- 1-1 Record keeping

Chapter 2 BUMEDINST 6600.10A CHAPTER MODIFICATIONS

Page

- 2-1 chapter 2 - Universal Precautions
- 2-1 a. Protective Attire and Barrier Techniques
- 2-2 b. Preparation of the Dental Treatment Room (DTR)
- 2-2 c. Treatment
- 2-2 d. Disinfecting the DTR Between Patients
- 2-2 e. Securing the DTR the end of the day
- 2-3 f. Housekeeping
- 2-3 g. Laundry
- 2-3 chapter 3 - Handwashing
- 2-3 a. Sharps exposure
- 2-4 chapter 4 - Sterilization
- 2-4 a. Monitoring
- 2-4 b. Carbide burs and diamond burs
- 2-4 c. Aluminum bur blocks
- 2-4 d. Test tubes
- 2-4 e. Processing
- 2-5 chapter 6 - Prosthodontics and Orthodontics
- 2-5 a. Prosthodontic Laboratory Infection Control

Chapter 3 ODONTOGENIC INFECTIONS

Page

- 3-1 Guidelines for Post-operative Care of the Surgical Patient
- 3-1 Guidelines for the Management of Patients with Odontogenic Infections
- 3-2 Subjective, Objective, Assessment, Plan (SOAP) format for documenting treatment of post-treatment infections

Chapter 4

NEEDLESTICK/SHARPS INJURY OR MUCOUS MEMBRANE CONTACT

Page

- 4-1 Purpose
- 4-1 Background
- 4-1 If Injured by a Needle or Other "Sharps"
- 4-1 Reporting
- 4-2 Action
- 4-3 Algorithm for Needle Stick or Mucous Membrane Exposure to
Blood or Body Fluid

Chapter 5

WASTE MANAGEMENT

Page

- 5-1 Waste Classification
- 5-1 Infectious Waste Bags and Sharps Containers
- 5-2 Liquid Infectious Waste
- 5-3 Clean-up of Infectious Waste Spills
- 5-3 Storage and Disposal of Infectious Waste

Chapter 6

MONITORING INFECTION CONTROL COMPLIANCE

Page

- 6-1 Command Infection Control Officer
- 6-1 Branch Clinic Infection Control Officers

Forms

NDCSD 6600/10-1 (Rev 11-92)

General DOR Infection Control Checklist

NDCSD 6600/10-2 (Rev 11-92)

CSR Infection Control Checklist

NDCSD 6600/10-3 (Rev 11-92)

Dental Lab Infection Control Checklist

NDCSD 6600/10-4 (Rev 11-92)

Command Infection Control Policies For New Staff Members

NDCSD 5102/1 (Rev 2-91)

Supervisor's Mishap Report

NDCSD 6600/10 (8-91)

Infection Control Report Chronology of Treatment

Chapter 1
GENERAL INFORMATION

1. Record keeping. Training records are maintained by the NDCSD Command Education and Training Officer.

Chapter 2

BUMEDINST 6600.10A CH-2 CHAPTER MODIFICATIONS

Policies set forth in reference (a) will be strictly followed. This chapter gives additional command policy on topics covered in reference (a), on a chapter-by-chapter basis. Subsequent chapters of this enclosure, give policy on infection control topics not covered in reference (a).

1. Chapter 2 - Universal Precautions

a. Protective Attire and Barrier Techniques

(1) Scrubs. Full scrubs will be worn in all patient treatment areas. Street clothes are not to be worn under full scrubs. Scrubs may be kept in personal lockers at lunch time but preferably on a hook outside the locker.

(2) White Lab Coats (Not considered Personnel Protective Equipment). White lab coats are one alternative to cover scrub attire. Since scrub attire is not allowed outside the clinical treatment spaces. The other alternative is changing from scrubs to uniform of the day for active duty military or civilian attire for civilian personnel. If white lab coats are chosen to be worn, the wearer is responsible for the weekly washing and pressing of the lab coat. White lab coat are not to be worn while treating patients.

(3) Protective Head Gear. Disposable protective head gear must be worn during surgical procedures or when splatter or aerosol contaminants are excessive. The head gear should be thrown away after each patient. Personal head gear is not allowed.

(4) Face Masks. Masks can be the cup or the tie version.

(5) Shoes. When in full scrubs, washable (cleanable), neat, inconspicuous, leather or canvas shoes which cover the toes must be worn. Shoes will remain in the dental facility. Shoe covers need to be available for covering "street shoes".

(6) Jewelry. Jewelry must not be worn under gloves during patient care. Earrings are to be the stud style and not to be long and dangling which can be contamination with aerosol while hanging over the patient being treated.

(7) Hair. All providers must ensure that their hair does not dangle in front their faces or in the treatment area. If the provider has long hair, it must be pulled back and properly secured. Hair should be covered with a head cover when aerosol spray is generated.

b. Preparation of the Dental Treatment Room (DTR). Radios in the DTRs should be covered with plastic bags or clear plastic wrap.

c. Treatment

(1) Patient Protection.

When aerosols are produced, use of a patient napkin or a patient drape is required. When aerosols are not produced e.g., diagnosis and routine examination, use of a patient napkin is recommended but not required.

(2) Biohazardous Waste.

All dental treatment room waste with blood material which is wet enough to come off when touched by a glove is considered contaminated and should be disposed of in a biohazard container, pre-labeled bags -or plastic bags with a biohazard sticker. This includes all gauze, cotton rolls, teeth, and tissue material. All biohazard waste is then to be double bagged, labeled “noninfectious waste”, autoclaved and disposed of in a locked dumpster labeled hazardous waste. All sharps containers must have the clinic’s address, room number and the date started on each container. All sharps containers are good for only 6 months or when $\frac{3}{4}$ full.

d. Disinfecting the Dental Treatment Room Between Patients

(1) Cleanup.

(a) If the handpieces are to be lubricated in the dental treatment room, lubricate them now and run for 5 seconds directing the spray into the High Volume Evacuator (HVE). If sterilized in CSR, transport to CSR after flushing lines.

(b) Magnification eyewear, safety glasses, and regular prescription eye glasses used during aerosol producing patient treatment must be disinfected. Face shields may be used to avoid infection of magnification eyewear and prescription eyewear.

e. Securing the Dental Treatment Room at the End of the Day.

(1) Daily Cleanup.

(a) Clean the amalgam trap in the dental unit. Remove non-amalgam items from traps with forceps and discard these items into the regular trash. Amalgam is emptied into a dry HgX scrap amalgam container located in each dental treatment room.

(2) Weekly Cleanup.

(a) Uncarpeted floors in patient treatment areas are to be disinfected weekly (and in CSR and Surgery spaces daily). Floor mops are to be disinfected after use by immersion in a fresh solution of sodium hypochlorite 1:100 dilution for 10 minutes, rinsed, and allowed to air dry. Pine oil cannot be used as a disinfectant, it is only a detergent.

(b) Amalgam traps are to be changed weekly on routinely used units. Once emptied, they are to be discarded into regular trash containers.

(c) Barriers used on non-hightouch areas should be changed weekly.

f. Housekeeping. All cleaning supplies are to be stored separately from patient treatment supplies. Patient treatment supplies are not to be stored under sinks in any of the dental treatment rooms but cleaning supplies can. However, if a plastic barrier (bag or hardsided plastic container) is used for patient items, they may be stored under the sink.

g. Laundry

(1) Linen Rooms. The linen room must have clearly marked areas “clean” for storing and issuing, and “dirty” for receiving dirty linen. This will eliminate cross contamination of the “clean” linen. Clean linen must be stored and issued from the clean side of the CSR.

(2) Handling and Sorting. Soiled linen will be handled as little as possible and with minimum agitation to prevent gross microbial contamination of the air and to the persons handling the linen.

(3) Linen Handlers. Each branch dental clinic will assign a linen petty officer to pick up soiled linen and centralize it for collection by the laundry service. The linen petty officer will adhere to guidance provided by OPMAN department in the performance of his/her duties. Soiled linen handlers must exercise caution not to contaminate themselves or any clean linen.

3. Chapter 3 - Hand Washing

a. Sharps Exposure

After an occupational exposure or an exposure incident involving a sharps injury, wash area of exposure with a disinfectant soap and water. Follow sharps exposure guidelines as stated in Chapter 4.

4. Chapter 4 - Sterilization

a. Monitoring

(1) Internal and external chemical indicators should be associated with every sterilized item.

(2) A-Test for all steam sterilizers.

(3) Place a biomonitor in one test tube or foil wrapped block, retrieve and send for culture testing (to Medical if your treatment facility does not have culture medium) following manufacturer's recommendations.

b. Carbide Burs and Diamond Burs. NEVER USE A BUR BRUSH TO DEBRIS BURS. Bur brushes present a great health hazard in that they are not readily disinfected or sterilized, they splatter contaminated debris over a wide area, and present great risk for "sharps" injury during use.

c. Aluminum Bur Blocks. Aluminum bur blocks need to be used instead of test tubes whenever possible. This allows the burs to be ultrasonically cleaned and then wrapped for heat sterilizing. Bur blocks are to be wrapped in aluminum foil. If burs are stainless steel, placing them in paper plastic wraps and autoclaving is possible. If burs are not stainless steel, autoclaving will rust them. A dry heat sterilizer must be used. A dry heat internal chemical process indicator is to be placed in each bur block being sterilized. The indicator is to be folded in half, lengthwise, to stick onto itself and not the instruments for ease of insertion and removal. The sterilization date should be written on the indicator strip. This is to indicate blocks if a positive spore test occurs. Wrapped bur blocks have a 30 day shelf life.

d. Test Tubes. If bur blocks are not available, test tubes can be used to hold the burs. Each test tube must have a phenolic cap to close the top. Each must also have an indicator strip placed inside as in the aluminum bur blocks. The burs must be completely dry before heat sterilizing or all the burs will rust.

e. Processing. When processing, the manufacture's operating instructions concerning temperature and time required for sterilization must be followed. The internal indicator strip must change color, if it does not, increase the time by 15 or 30 minutes. The burs can be placed on a tray or rack during sterilization, whichever the sterilization will accommodate.

6. Chapter 6 - Prosthodontics and Orthodontics

a. Prosthodontic Laboratory Infection Control

(1) Personnel protection of masks and eye wear are to be worn whenever grinding, polishing, or working with any rotary instruments.

(2) A designated area in the dental laboratory should be assigned for disinfecting all incoming and outgoing items. Items coming into the dental laboratory must be rinsed, debried, and disinfected before entering the laboratory area. A waiver is given for any prosthesis that requires tinting or shading. Items going out of the dental laboratory must be disinfected.

(3) When working with contaminated items, work areas should be covered with paper that is changed at completion of each contaminated case.

Chapter 3 ODONTOGENIC INFECTIONS

1. Guidelines for Post-operative Care of the Surgical Patient

- a. All patients undergoing oral surgical/invasive procedures are to receive verbal and written instructions for post-operative care, including where to return if they experience a problem.
- b. All patients undergoing oral surgical/invasive procedures will receive a post-operative evaluation appointment with the exception of very minor/routine surgical cases. However, post-operative evaluation appointments will be made for all medically compromised patients (e.g., uncontrolled "brittle" diabetic, steroid dependent, immuno-depressed, etc.).

2. Guidelines for the Management of Patients with Odontogenic Infections

- a. Patients presenting with oral infection will have the condition, appropriate treatment, and follow-up instructions documented in their dental record and in an Odontogenic Infection Tracking Log Book.
- b. An Odontogenic Infection Tracking Log Book will be used to report and monitor infections. This will be located in oral surgery at all clinics. At the main clinic where the emergency duty section is held, there will also be an Odontogenic Infection Tracking Log Book located in oral diagnosis during normal working hours and moved into the emergency duty operatory for the duty section. The initial treatment and all follow up treatments must be written in this log book and the patient's record until the infection is resolved. The attending dental officer is responsible for proper follow-up, referrals, or managing the infection to completion. Watchstanders unable to follow the case are responsible for appropriate referrals. Every attempt must be made not to lose a patient to follow-up. Accuracy and legibility of the patient data (name, SSN, phone numbers, etc.) and treatment notes are essential to tracking these cases. A tracking mechanism must be established for patients referred to another treatment facility. If efforts made to contact a patient are unsuccessful and a patient is lost to follow-up, this must be documented in the log book. The Infection Control Officer will review the book daily to make sure patients are being followed up and for possible trends including those that could indicate nosocomial infections, and report the findings to the ECODS.
- c. When the log book is open, the initial entry is to be written on the left side of the page starting with all of the patient's identifying information. Any additional entries are to be continued on that page and then onto the right page when the left side is full. No other case should be written on those two pages. Unresolved cases will be tagged with red tape on the left page. All closed cases will be indicated by covering the red tape with white tape.

d. All outpatients under treatment for unresolved odontogenic and post-surgical infections, satisfying the following criteria, require consultation to an oral/maxillofacial surgeon or to a medical officer when an oral/maxillofacial surgeon is not available:

- (1) Extension beyond the alveolar process and vestibular space; and/or
- (2) Evidence of fever, lymphadenopathy, or other systemic involvement; and
- (3) Showing no evidence of improvement within 24-48 hours following the initiation of treatment for the infection.
- (4) Any condition which warrants close monitoring.

e. Upon hospital admission to a dental service, a patient with odontogenic and post-surgical infections will have a formal consultation with appropriate medical specialist(s) documented in the patient's chart. A team approach with formal consultation must be used, since these non-resolving infections may progress rapidly to ascending or descending fascial spaces and result in a life threatening emergency.

3. SOAP Format for Documenting Treatment of Post-operative Infections

a. Standards of care, mandate that all patients referred to the naval hospital for treatment of post-operative infections or other complications will have their cases reported to the hospital Quality Assurance Committee for evaluation. The dental record is open for review by this committee. A record that is incomplete or inadequate reflects adversely on the command and the dental officers involved. Therefore, we are compelled to document all aspects of diagnosis and treatment, and to try our best to follow up on the patient. The following are aspects of care and evaluation that should be addressed in the dental record as soon as you are aware that the patient is developing an infection.

(1) S- (SUBJECTIVE) Write down the patient's symptoms, whether they are improving or worsening with time. Document the absence or presence of dysphagia and/or respiratory distress. Ask the patient what the chief complaint is, and then quote the individual (i.e., "It hurts to swallow").

(2) O- (OBJECTIVE) Record a thorough analysis of the size and character of any swelling, remarking on presence or absence of fluctuance, induration, tenderness, and inflammation. The location of the swelling is extremely important in identifying which fascial spaces are involved. Measure the amount of trismus (if present).

(a) Examine the neck and note the presence (and location) or absence of lymphadenopathy.

(b) Record whether or not purulence and drainage is present, it's amount, odor, and color.

(c) Record the patient's temperature and other vital signs and whether or not the patient has been experiencing chills and fevers.

(d) Note the quality of the airway. This is absolutely essential in any evaluation of head and neck infection. Evaluate the pharynx, note whether the uvula is midline and if there is any swelling of the pharyngeal walls.

(e) Remark on the patient's general condition. Is he/she septic and lethargic or does he/she appear alert and animate.

(f) Evaluate the patient's past medical history and note any contributing details such as systemic illness, medications, allergies, etc.

(3) A- (ASSESSMENT) Now, take all of the above signs and symptoms and write down your evaluation of the patient's condition. Address specifically which fascial space is involved, whether the patient's condition is improving or worsening, and whether the airway is secure. Record whether treatment to this point has been effective or ineffective in your estimation.

(4) P- (PLAN) Write down your plan for treatment of the patient. This should include antibiotic doses, incision and drainage if appropriate, culture and sensitivity testing (C & S), and Gram Stain. Also include any consultations you seek from other specialties, even if the consult is only an oral one.

b. This patient must be seen daily! Make sure that you record that the patient was told to return daily. If the patient will be evaluated over the weekend, record how that will be done. If the duty officer is going to see the patient, make sure that the duty officer sees the patient with you, if possible, and you must apprise the duty officer of the patient's condition. Record that in the chart as well.

c. Should the patient be referred to the hospital for care, send a consult (SF-513) with the patient, list treatment and responses to treatment up to the point of referral. Call the oral surgery department at the hospital, advise them of the patient's condition and ensure the patient has transportation, either privately owned vehicle (POV), ambulance, or dental van.

d. This format should be used every time the patient is seen for treatment. With dental infections, it is good practice and in the best interest of the patient to document everything.

Chapter 4

NEEDLESTICK/SHARPS INJURY OR MUCOUS MEMBRANE CONTACT

1. Purpose. To provide a uniform policy and standardized procedures for reporting, evaluation, counseling, and guidance of personnel subjected to needle/sharps stick or mucous membrane exposure to blood or body fluids. To ensure access of our health care providers and other staff members to optimal medical care related to initial and subsequent testing for seropositivity following "sharps injury".

2. Background. Dental health care personnel are at occupational risk for needle/sharps stick and mucosal exposure to blood and body fluids. An exposure incident can result in Human Immunodeficiency Virus (HIV) or Hepatitis B (HBV) infection to the health care provider. Step by step procedures must be followed, should a health care provider be exposed, in order to ensure proper diagnosis and follow up care as required.

3. If Injured by a Needle or Other "Sharps"

a. When a "sharps" injury occurs, the injured site should be scrubbed immediately with an antimicrobial hand wash, such as 4 percent chlorhexidine gluconate or povidone iodine (an iodophor consisting of a complex of iodine with polyvinylpyrrolidone).

4. Reporting

a. Military and civilian personnel that experience accidental puncture or have mucous membrane contact, are to report the incident immediately to their supervisor (leading petty officer (LPO) or department head) who will complete a Supervisor's Mishap Report. The exposed individual, accompanied by the patient (if available), shall then promptly report to the acute care area (ACA) of medical for consultation, evaluation, and treatment within one hour of the exposure.

b. The immediate supervisor will initiate a Supervisor's Mishap Report (form NDCSD 5102/1) and ensure the original and one copy are forwarded to the Command Safety Manager as soon as possible, but no later than seven workdays. The safety manager will forward the copy to the Command Quality Assurance Coordinator.

c. The immediate supervisor will refer the exposed individual and source patient (if available) to medical via a Consult Form (SF-513), for military personnel and the Civilian Dispensary Permit, OPNAV Form 5100/9, for civilian personnel.

5. Action

a. Directors, Branch Dental Clinics.

(1) Ensure diagnostic and treatment procedures prescribed by the medical officer are followed. This includes a review of the medical record and history of the source patient to access the likelihood of HIV and/or HBV infection. Also, to make sure both the source patient and the health care provider are tested for HIV and hepatitis B surface antigen (HBsAg).

(2) Ensure personnel subjected to needle stick or mucosal exposure to blood or (R) body fluids are reported, diagnosed, and when indicated, treated. Military, GS, and contract civilian personnel will be required to report to the nearest branch medical clinic Occupational Health department for appropriate treatment.

b. Infection Control Officer and Command Safety Manager.

(1) The Infection Control Officer will provide education and training on risks, prevention and management of needle stick and mucosal exposure to blood and body fluids as requested by medical personnel and as outlined in this instruction. The Infection Control Officer will also provide training on the Navy's Tuberculosis (TB) Policy.

(2) Upon receipt of a Supervisor's Mishap Report, the Command's Safety Manager will ensure corrective action is implemented and followed through.

c. Medical Acute Care Area Management Protocol.

(1) The exposed individual, and the source patient (if available), shall report to medical within one hour after the exposure occurred. The physician or health care provider (HCP) responsible shall review the medical record and case history of the source patient in order to access the likelihood of HIV and/or HBV infection.

(2) Initial Laboratory Studies. The patient will be tested for HIV and hepatitis B surface antigen (HBsAg) (with informed consent). The consult for HIV testing (HIV Serology Request Chit, NHSD 6320/2), shall be clearly labeled "needle-stick injury – process immediately" and the "24-hour result needed (call 532-8825)" box checked. In the event that the source patient is known to be HIV seropositive, the exposed individual will be referred immediately (within one hour after exposure) to the infectious disease division of the Naval Medical Center, San Diego, for evaluation and to expedite obtaining test results.

(3) Section 6. below is to be utilized as the treatment protocol algorithm. Treatment protocol algorithm summary:

(a) Hepatitis B Prophylaxis. The hepatitis B immune status of the HCP will be assessed with an HBsAg and an Anti-HBs ran to determine whether he/she has had a subclinical case of hepatitis B. This is necessary since 80 percent of the hepatitis B cases are subclinical. If the health care worker is positive for either the HBsAg or anti-HBs, no further treatment is necessary, besides scrubbing the exposed site with an anti-microbial disinfectant. If both these tests are negative and the source patient is HBsAg positive, and if the HCP was not previously vaccinated against hepatitis B, the series will be started immediately (Recombivax 10mcg/1.0 cc I.M. in deltoid day 0, month one, and month six). Hepatitis B immune globulin (HBIG) will also be given to the HCP in the event the source patient is HBsAg positive (0.06 ml/kg I.M. within seven days of exposure). Immune serum globulin can be optionally given to prevent non A-non B hepatitis (0.06 ml/kg I.M.) as soon as possible after exposure.

(b) The risk of contracting HIV from a needle stick is low. The estimated risk is 1:200 to 1:250. There is a higher risk if a volume of blood or blood products is injected at the time of the sharp exposure. However, there is a need to be concerned. The patient needs to have an evaluation by medical for HIV. The infectious disease division will review cases thought to be at significant risk for HIV transmission, in order to determine the potential use of zidovudine prophylaxis, which has been recommended by some for this situation. However, AZT prophylaxis has not been proven to be efficacious. The use of AZT in seronegative individuals remains controversial, and AZT has caused cancers in laboratory animals. The recommended HIV testing to be performed on the HCP will be at time of exposure, six weeks, 12 weeks, six months or unless more frequent testing is clinically indicated (annual testing for HIV is a requirement for active duty personnel). The subsequent development of a mononucleosis-like illness or aseptic meningitis shall be an indication for an infectious disease consultation. Individuals who have been exposed to HIV or hepatitis B infected materials are advised to adhere to the Center for Disease Control (CDC) recommendations including "safer sex" to minimize the potential for transmission to others for a period of approximately six months. There are very few documented cases of seroconversion or infection at a period of time longer than six months.

6. Algorithm for Needle Stick or Mucosal Exposure to Blood or Body Fluid. In the event of a needle stick, the following medical procedures will be completed:

a. All patients must:

(1) Clean the wound.

(2) Administer tetanus prophylaxis if immunization is not current.

- (3) Counsel patient concerning hepatitis and HIV.
- (4) Test the source patient (if available) for HIV screen and hepatitis profile.
- (5) Test exposed provider for HIV screen and hepatitis profile.

Was sharps contaminated with blood or body fluids?

/	\
YES	NO
/	\
/	Complete hepatitis vaccine series or consider
/	initiating vaccine series IAW NAVMEDCOMINST
/	6230.1A series
/	

Enter Part I and Part II of the table provided below.

Part I. Determine the infectious status of the source and immunization status of the exposed person. Enter the table below to determine what immediate action to take.

Key: S = Source E = Exposed person

INFECTIOUS STATUS OF THE SOURCE	IMMUNIZATION STATUS OF THE EXPOSED PERSON	
	<u>HEPATITIS VACCINE SERIES NOT DOCUMENTED OR INCOMPLETE</u>	<u>HEPATITIS VACCINE SERIES COMPLETE</u>

<u>HBsAG POSITIVE</u>	S: HIV screen E: Hepatitis profile HIV screen HBIG 0.06 ml/kg at once	S: HIV screen E: Anti-HBs test HIV screen
------------------------------	--	---

<u>HIV POSITIVE</u>	S: Hepatitis profile E: Hepatitis profile HIV screen	S: Hepatitis profile E: HIV screen Anti-HBs test
----------------------------	--	---

<u>HBsAG & HIV UNKNOWN</u>	S: Hepatitis profile HIV screen E: Hepatitis profile HIV screen	S: Hepatitis HIV screening profile HIV screen E: Hepatitis profile HIV screen
<u>SOURCE UNKNOWN</u>	E: Hepatitis profile HIV screen	E: Hepatitis profile HIV screen

Part II. Enter this table when initial laboratory results are known to determine what follow-up action to take:

INFECTIOUS STATUS OF THE SOURCE	IMMUNIZATION STATUS OF THE EXPOSED PERSON	
	<u>EXPOSED WITH INADEQUATE ANTI-HBs TITER</u>	<u>EXPOSED WITH ADEQUATE ANTI-HBs TITER</u>
<u>Hbsag POS</u>	Administer HBIG 0.06 ml/kg (if not given already). Initiate or complete hepatitis B vaccine series. If vaccine series is complete, give one booster dose.	If vaccine series is not complete, continue series As scheduled.
<u>Hbsag NEG</u>	Initiate or complete vaccine series. If vaccine series is complete, give one booster dose.	If vaccine series is not completed, continue series as scheduled.
<u>HBsAg UNKNOWN</u>	Initiate or complete vaccine series, If vaccine series is complete, give one booster.	If vaccine series is completed, continue as scheduled.
<u>HIV POSITIVE OR UNKNOWN</u>	Initiate medical consult and counseling. Schedule additional HIV screening at 6-8 weeks and 3, 6, and 2 months after exposure.	

HIV Negative Document only.

Notes:

1. Anti-HBs testing is not necessary if exposed person had adequate anti-HBs within the last 12 months.
2. Adequate anti-HBs is defined as anti-HBs equal to or greater than 10 standard ratio units (SRU) by RIA or EIA.
3. High risk sources for hepatitis B:
 - a. Immigrants from China, Southeast Asia, Pacific Islands, and Haiti.
 - b. Parenteral drug abusers.
 - c. Homosexual and bisexual males.
 - d. Household contacts of HBV carriers.
 - e. Hemodialysis patients.
 - f. Acute or chronic liver disease patients.
 - g. HIV positive individuals.

Chapter 5

WASTE MANAGEMENT

1. Waste Classification

a. Infectious (biohazardous) waste: A solid or liquid that contains pathogens in adequate numbers and with sufficient virulence to cause infectious disease in susceptible hosts exposed to the waste. It is thought that this waste could pose a threat to human health or the environment. This type of waste includes:

(1) Sharps - hypodermic needles, syringes and scalpel blades, orthodontic wires, endodontic files/reamers, matrix bands, anesthetic carpules or anything that could puncture or cut.

(2) Blood or Other Potentially Infectious Materials (OPIM e.g., saliva, nasopharyngeal secretions, etc.).

(3) Items contaminated with blood and other potentially infectious materials (OPIM, e.g., saliva, nasopharyngeal secretions) that would release these substances in a liquid or semi-liquid state, if compressed, or if caked with dried blood or OPIM and are capable of releasing these materials during handling.

(4) Extracted teeth.

(5) Pathological waste - human tissues other than extracted teeth.

(6) Microbiological waste - live cultures (e.g., "positive control" spore tests).

b. Non-infectious (medical solid) waste: Medical waste which does not pose a significant risk of causing or transmitting communicable disease or infection under ordinary circumstances. Infectious waste which has been autoclaved or sterilized.

2. Infectious Waste Bags and sharps Containers

a. Sharps containers and biohazard bags will be labeled prior to use. The following information will be placed on the container or bag:

Biohazard Bag

Clinic's Name

Clinic's Address

Room Number

Date Sterilized

Sharps Container

Clinic's Name

Clinic's Address

Room Number

Date Started

b. Labeling will be completed by the supply petty officer as soon as containers or bags are received at the clinic. Indelible ink will be used, either using preprinted/stamped moisture proof, firmly adhering labels or by printing/stamping directly on the container.

c. Biohazardous waste will be placed in the bag or container at the point of origin.

d. Sharps containers must be tamper-proof. They must not be readily tipped over and should be mounted to cabinets, carts, or bulkheads, out of easy reach of patients.

e. Sharps containers must provide a means of removing needles from syringes unless the container will be used solely for disposal of items other than needles (e.g., anesthetic carpules, matrix bands, etc.).

f. Sharps containers will be tape sealed, and will be removed from use for disposal when 3/4 full or after six months of use.

g. Putrescible waste - that which is likely to develop a foul odor - (e.g., extracted teeth or blood soaked gauze) will not be placed in sharps containers. These items will be placed in biohazard bags.

h. Biohazard waste bags will be sufficiently thick and durable to prevent rupture or leakage. Bags will be labeled with biohazard symbol or will be red in color.

i. When used, biohazard waste bags will be tightly sealed and will be removed from the operatory as soon as possible.

j. If waste is removed to another area (e.g., the Medical Clinic) for processing or disposal, it will be placed in a second container, prior to being transported.

3. Liquid Infectious Waste

a. Liquid infectious waste will be suctioned through the central evacuation system.

b. If a self-contained suction apparatus (i.e., Gomco) is used as an emergency backup, the liquid waste will be disposed of by pouring liquid into the sanitary sewer through CSR sinks, rather than handwashing sinks. The suction canister will be properly processed and autoclaved prior to reuse.

4. Clean-up of Infectious Waste Spills

a. Any spill of infectious waste will be cleaned immediately. A large spill should be cleaned up by using a bio-spill kit which should be maintained in CSR at every clinic.

(1) Contents of a biospill kit.

(a) Head cover, goggles, mask, protective gown, foot covers, heavy rubber gloves, two sponges, biohazard bag, tongs, whisk broom, dust pan, spray bottle of bleach, and spill kit flow chart.

b. Personal protective apparel, including gloves, mask, eye-protection, and where appropriate, footcovers, will be worn when cleaning any spill.

c. Blood or body fluid spills will be absorbed into sponges which will be then disposed of properly.

d. Broken or leaking containers will be placed in new containers and will be properly sealed.

e. The spill area will be disinfected with an EPA approved hospital disinfectant or a 1:10 solution of household bleach and water.

5. Storage and Disposal of Infectious Waste.

a. A log will be used to track disposal of solid infectious waste. The log will note date, type, amount of waste (volume, weight, or number of containers) and disposition.

b. Each Branch Dental Clinic will adhere to local regulations for storage and disposal of solid infectious waste.

Chapter 6

MONITORING INFECTION CONTROL COMPLIANCE

1. Command Infection Control Officer (CICO). The command infection control officer will conduct ongoing monitoring of infection control procedure compliance within the command. The command representative for infection control is not required to provide advanced notice of an inspection visit. The ICO may hold meetings with outlying clinic infection control officer as deemed necessary. The command infection control officer will ensure infection control functions are addressed at least quarterly as part of the command Quality Assurance Program, by submitting quarterly reports to the Executive Committee of the Dental Staff (ECODS). The infection control officer may conduct inspections of branch clinics to ensure that infection control guidelines set forth in this manual are being followed as deemed necessary. After-action reports are to be submitted by the clinic directors, to the command infection control officer, following these inspections.

2. Branch Clinic Infection Control Officers (BCICO). Branch clinic infection control officer will conduct ongoing monitoring of infection control procedure compliance within the branch clinics. They may request assist visits by the command infection control officer, or an appointed representative, as needed. Branch clinic infection control officer will conduct quarterly self-assessment inspections utilizing forms NDCSD 6600/10-1, -2, and -3. A summary of these inspections will be forwarded to the command infection control officer. The Branch infection control officers provides regular communication to the branch director, senior enlisted leader and department leading petty officers.

INFECTION REPORT

Date: _____

Patient's Name: _____ SSN: _____

Unit: _____ Telephone #: _____

Doctor's Name: _____ Clinic: _____

Site of Infection: _____

Oral Temperature: _____

Results

Gram Stain: ☐ No ☐ Yes _____

Culture and Sensitivity: ☐ No ☐ Yes _____

History of Present Illness: _____

CHRONOLOGY OF TREATMENT

Date: _____ Tx: _____

Date: _____ Tx: _____

Date: _____ Tx: _____

Date: _____ Tx: _____

Date: _____ Tx: _____

Date Infection Resolved: _____

UPON COMPLETION, THIS FORM MUST BE FORWARDED TO THE COMMAND
INFECTION CONTROL OFFICER VIA THE CLINIC DIRECTOR.

GENERAL DOR INFECTION CONTROL CHECKLIST

DATE: _____

1. GENERAL DOR CONSIDERATIONS:	YES	NO
a. Is the DOR clear of unnecessary materials, objects, and equipment? 1. Personal gear?		
b. Is food or beverage in the DOR?		
c. Are all containers labeled with contents and expiration dates?		
d. Is appropriate soap dispenser available? Not empty? (including heads) 1. Sink clear of instruments?		
e. Trash cans lined? 1. Overflowing?		
f. "SHARPS" container available? 1. Labeled with name, address, and phone number of generator? 2. Too full? (Full when 3/4 filled.) 3. Sent to CSR when 3/4 filled?		
g. Biocide or Cavicide disinfectant spray bottle available? 1. Spray bottle labeled by manufacturer? 2. Mixed /used according to manufacturer's instructions in central location? 3. Solution changed daily? Date of mixing affixed?		
h. Items on countertops, desks, and walls cleanable? (cleaned when visibly soiled)		
i. Irrigation solutions dated for expiration? (one week from time of opening; solutions used for surgical procedures, one day)		
j. Overall, is DOR clean?		

REMARKS:

2. PATIENT, DOCTOR, AND TECHNICIAN:	YES	NO
a. Masks, gloves, safety eyewear, clean scrubs and gowns (when required) being used by doc and tech?		
1. Gloves and masks NEVER worn outside DOR! (Except when taking instruments to CSR)		
b. Scrubs and gowns changed daily or when visibly soiled prior to the end of the day?		
1. Gowns stored properly in clinical spaces between patients?		
c. Docs and techs protected with heptavax?		
d. Patient using Peridex 30 second rinse, other mouthwash, or brushing before procedure?		
e. Patient draped (when indicated) and wearing safety glasses?		
f. Rubber dam used where indicated?		
g. Needles recapped properly if there is a need to recap? (One hand scoop or device)		
h. High speed evac used with high speed handpiece?		
i. Proper handwashing technique used? Before and after gloving? All jewelry removed?		
j. All safety eyewear disinfected between patients?		

REMARKS:

3. INSTRUMENT PACKS AND DRAWERS:	YES	NO
a. All packs properly wrapped, labeled with sterilizer ID/run number, dates (steril/expir), tech's name, and stored away from aerosol contamination?		
b. Drawers free of unsterilized instruments and equipment (that can be sterilized)?		
c. Sterilized burs in test tubes or foil-wrapped bur blocks? Labeled?		
d. All high speed handpieces and low speed attachments sterilized between use?		
e. Bulk supplies stored in cabinets, away from aerosol contamination?		
f. Consumables available during patient treatment? i.e. UNIT DOSE CONCEPT USED?		
g. Cleaning supplies stored separately from patient treatment supplies?		

REMARKS:

4. DENTAL UNIT, CHAIR, AND INSTRUMENT SETUP:	YES	NO
a. Hard to disinfect surfaces covered with plastic? Replaced after each patient?		
b. "Spray-wipe-spray" technique used with surface disinfectants?		
c. Instrument pack set up for "Unit Dose"?		
d. Tech and doc using "Unit Dose" concept? Setting out appropriate instruments and materials before starting procedure?		
e. Instruments placed on disposable non-porous barrier? i.e. pack wrapper.		
f. Hand-operated controls, switches, and handles (high touch areas) disinfected after each patient?		
f. Counter tops, chair, unit, and light disinfected daily?		
g. High speed evac and saliva ejector lines flushed at end of day with appropriate cleaner?		
h. All water lines flushed first thing in the morning at least 1 minute?		
1. Sterile handpieces lubricated and run for 15 seconds before patient treatment?		
2. After patient treatment, handpieces lubricated and run for 30 seconds?		
3. Then, handpiece lines flushed for 30 seconds without handpiece attached?		
i. Tri-plex syringe tips changed or disinfected between patients?		
j. Is the tech wearing gloves, mask, and eye protection during cleanup?		
k. Floors cleaned routinely? (Weekly or when spills occur)		
l. Amalgam traps clean? Replaced weekly on units routinely used?		
m. Headrest covers changed between patients?		

REMARKS:

CSR INFECTION CONTROL CHECKLIST

DATE: _____

1. GENERAL CSR CONSIDERATIONS:	YES	NO
a. Is the CSR clear of unnecessary materials, objects, and equipment?		
1. Personal gear?		
b. Are food or beverages in the CSR?		
c. Are all containers labeled with contents and expiration dates?		
d. Is appropriate soap dispenser available? Not empty?		
1. Sink clear of instruments?		
e. Trash cans lined?		
1. Overflowing?		
f. "SHARPS" container available?		
1. Labeled with name, address, and phone number of generator?		
2. Too full? (Full when 3/4 filled.)		
3. When full: sealed, autoclaved, labeled "sterilized", thrown away as medical solid waste?		
g. Biocide/Cavicide disinfectant spray bottle available?		
1. Spray bottle labeled by manufacturer?		
2. Mixed/used according to manufacturer's instructions in central location?		
3. Solution changed daily? Date of mixing affixed?		
h. Items on countertops, desks, and walls cleanable? (cleaned when visibly soiled)		
i. If clean linen issued, only from "clean" side of CSR?		
j. Overall, is CSR clean?		

REMARKS:

NDCSD 6600/10-2 (Rev 11-92)

2. CSR TECHNICIANS:	YES	NO
a. Masks, utility gloves, safety eyewear, clean scrubs and plastic aprons being used by all CSR techs?		
1. Personal protective clothing/eyewear NEVER worn outside CSR!		
b. Scrubs changed daily?		
c. Techs protected with heptavax?		
d. All jewelry removed?		

REMARKS:

3. INSTRUMENT PACKS AND DRAWERS:	YES	NO
a. All packs properly wrapped, labeled with sterilizer ID/run number, dates (steril/expire), tech's name, and stored away from aerosol contamination?		
b. All high speed handpieces and low speed attachments sterilized between uses?		
c. Bulk supplies used for unit dosing inside packs stored in cabinets, away from aerosol contamination?		
d. Cleaning supplies stored separately from patient treatment supplies?		

REMARKS:

NDCSD 6600/10-2 (Rev 11-92)

4. STERILIZATION:	YES	NO
a. Instruments soaked in disinfectant for 10 minutes before handling?		
b. Instruments placed in ultrasonic cleaner with lid closed for time specified by manufacturer?		
c. Items checked for cleanliness?		
d. Instruments loosely wrapped?		
e. Chemical dosage indicators inside packs?		
1. Process indicator (sterilization tape) on outside of all packs?		
f. Packs should be identified with:		
1. Sterilizer/run number.		
2. Sterilization date.		
3. Expiration date.		
4. CSR tech's initials.		
g. Test tubes/bur blocks labeled with date of sterilization and number of sterilizer?		
h. Do not overload sterilizer.		
i. Autoclave cycle time and temp properly set?		
j. Dry heat sterilizer properly set? (1600 - 1710C or 3200 - 3450F for 30 min)		
k. Autoclaves and dry heat sterilizers tested weekly with biologic monitors?		
l. Biologic monitor results logged each week?		
m. Logs maintained for <u>each</u> sterilizer?		
1. Sterilization cycles?		
2. Biologic Monitoring?		
3. Repair and Maintenance?		
n. Infection control officer notified when equipment malfunctions? Positive spore tests? Etc.?		
o. Instruments allowed to cool before handling?		
p. Peel packs heat sealed or taped closed, and dated for expiration (180 days).		
q. "Dirty" side tech and "clean" side tech should be assigned at all times. "Dirty" side tech should not cross into "clean" side and vice versa.		
r. Biohazardous (infectious) material handled properly?		
1. Sharps containers sealed, autoclaved, labeled "sterilized", thrown away as medical solid waste?		
2. Red bags in clear bag, autoclaved, labeled "sterilized", thrown away as medical solid waste?		
s. Counter tops wiped with disinfectant daily?		
t. Deck swabbed daily with bleach or disinfectant?		

REMARKS:

DENTAL LAB INFECTION CONTROL CHECKLIST

DATE: _____

1. GENERAL LAB CONSIDERATIONS:	YES	NO
a. Is the lab clear of unnecessary materials, objects, and equipment? 1. Personal gear?		
b. Are food or beverages in the lab?		
c. Are all containers labeled with contents and expiration dates?		
d. Is appropriate soap dispenser available? 1. Sink clear of instruments?		
e. Trash cans lined? 1. Overflowing?		
f. Disinfectant spray bottle available? 1. Spray bottle labeled? 2. Mixed /used according to manufacturer's instructions in central location? 3. Solution changed daily? Date of mixing affixed?		
g. Overall, is the lab clean?		

REMARKS:

2. PERSONNEL PROTECTION:	YES	NO
a. All personnel protected with heptavax?		
b. Hands washed between cases?		
c. Antimicrobial soap and dispenser available?		
d. Gloves, masks, eye protection used when handling contaminated items?		
e. Long smock coats worn? Changed daily?		
f. All jewelry removed from hands and wrists?		

REMARKS:

3. IMPRESSIONS RECEIVED:	YES	NO
a. Gloves and protective attire worn?		
b. Rinse impressions under running water before pouring?		
c. Impressions disinfected before pouring when feasible?		
d. Slurry water prepared from fresh set stone which was not poured against an impression?		

REMARKS:

NDCSD 6600/10-3 (Rev 11-92)

3. PROSTHESES RECEIVED:	YES	NO
a. Gloves and protective attire worn?		
b. All prostheses/appliances scrubbed with a bacteriocidal soap?		
c. Prosthesis then placed in a container with disinfectant and that container placed in ultrasonic for 10 min?		
1. Ultrasonic covered?		
2. Ultrasonic disinfectant solution changed daily?		

REMARKS:

4. CASTS AND MISCELLANEOUS LAB ITEMS:	YES	NO
a. Gloves and protective attire worn?		
b. Casts disinfected with iodophor or bleach?		
c. Rag wheels, brushes, acrylic burs, and pumice changed for each contaminated prosthesis?		
d. Disinfectant added to pumice? (5 parts NaOCl + 3 parts green soap + 100 parts water)		
e. Before sand blasting, are all items scrubbed and disinfected for 10 min, and dried?		

REMARKS:

5. INTERIM AND NEW PROSTHESES:	YES	NO
a. Burs and instruments designated for use on new prostheses separated from those used on used prostheses?		
b. After completion of a case, are appliances disinfected for 10 min, and sealed in a plastic bag?		

REMARKS:

6. MISCELLANEOUS:	YES	NO
a. All barrier and disinfectant techniques maintained even on "rush" cases?		
1. Instruments used on contaminated cases sterilized after each case?		
2. Unit dose polishing:		
(a) Individually wrapped wheels?		
(b) Pumice catch pans?		
(c) Pumice or other polishing agents changed between cases?		
b. If two separate polishing lathes available, one for new and one for used prostheses?		
c. Daily disinfection:		
1. Spatulas, knives, wax carvers?		
2. Rubber mixing bowls?		
3. Chucks, handles, switches, tubing, air hoses, lab handpieces?		
4. Pumice, rag wheels and brushes used on new prostheses?		
5. Case receiving area and plaster bench?		
d. Weekly disinfection:		
1. Work stations, including exposed equipment, drawers, and work surfaces?		
2. Sinks?		

REMARKS:

INFECTIOUS DISEASE HAZARDS IN THE WORKPLACE
COMMAND INFECTION CONTROL POLICIES FOR NEW STAFF MEMBERS

1. Bureau of Medicine Instruction 6600.10A and Naval Dental Center, San Diego, Instruction 6600.10C constitute the command's exposure control plan, popularly known as the "DENTAL INFECTION CONTROL MANUAL". The purpose of these instructions is to establish policy that will help protect both dental staff personnel and patients from infectious diseases that can be spread by saliva, blood, bacterial plaque, water droplet splatter and aerosols.

Among the infectious diseases that you and your patients could acquire or transmit in the course of dental treatment are tuberculosis, hepatitis, staph and strep infections, herpes, AIDS, venereal disease, flu, and other upper respiratory tract viral and bacterial infections.

Because all sick or infected patients cannot be readily identified, it is important that you take every precaution to avoid unknowingly spreading infection in the dental office. Adherence to the mandates found in the command infection control manual will help protect you and your patients from serious disease.

2. COMMAND INFECTION CONTROL POLICIES include the following:

- All dental staff personnel within the command who may have either direct or indirect contact with a patient's blood and saliva will receive the hepatitis B vaccine immunization series. This will include clinical staff, civilian employees (civil service and contract), volunteers, dental laboratory, and dental repair personnel.

- Patients suspected of having hepatitis or other infectious diseases will be promptly referred to the nearest medical treatment facility for evaluation prior to initiating any routine dental treatment.

- All staff personnel involved in patient care will employ barrier techniques by wearing gloves, face masks and eye protection for all patient contact and during DTR disinfecting between patients. The Command will furnish and launder "scrub type" tops and bottoms and gown cover-ups. The scrubs and cover-ups will be changed at the end of the day or when visibly soiled prior to the end of the day. Shoes worn with full scrubs will be a washable (cleanable), plain type shoe, leather or canvas, not to be taken home at night. As an alternative, surgical shoe covers may be worn over other types of shoes.

- Aerosols in the work environment present a significant health hazard for both the dental staff and the patient. The following will reduce the microbial concentration of oral flora and/or decrease the infectivity of an aerosol: having patients brush their teeth or rinse with an antimicrobial mouthwash prior to receiving treatment; flushing the dental unit and handpiece water lines at the start of the morning at least 1 minute and after patient treatment at least 30 seconds, and using rubber dam whenever possible and high volume evacuators during all procedures generating aerosols. Face masks and eye protection will help protect the dental staff from aerosol generated infection.

- The command insists that the dental staff observe a standard protocol for decontamination and preparation of dental treatment operatories between patients to prevent the transmission of infection. All surfaces that may have been contaminated with a patient's blood, saliva, or with aerosol sprays or splatters must be disinfected. This includes the dental chair, unit, control buttons, light, countertops and other exposed work surfaces. An solution such as Biocide is sprayed on these items. The surfaces are then wiped off with a paper towel to remove all debris and particulate matter. The surfaces are then re-sprayed which disinfects after 10 minutes contact time.
IODOPHOR NDCSD 6600/10-4 (Rev 11-92)

- Handwashing is considered one of the most important procedures for preventing the transmission of clinic-borne infections. Hands must always be washed prior to gloving, after degloving, after touching any object likely to be contaminated by blood, saliva, or other body fluids, and before leaving the dental treatment room. An ideal antimicrobial surgical soap is Chlorhexidine gluconate.

- The command is extremely concerned about protecting the health of personnel who might suffer a needlestick, cut or puncture from a contaminated instrument, or mucous membrane contamination. If you should suffer such an injury, you must not hide this fact. You must report this occurrence to your immediate supervisor. Certain tests and other measures must be undertaken immediately to protect your health. Details of these measures are found in chapter 4 of the command's infection control instruction.

The previous paragraphs highlight just a few of the important features of the Dental Infection Control Manual. You will find a copy at each branch dental clinic in this command. It covers many specific areas including: universal precautions; handwashing; sterilization and disinfection; infection control in prosthetic operatories and laboratories; x-ray facilities; central sterilization rooms; odontogenic infections; waste management; inspections; training, and many other pertinent topics to be aware of in order to protect your health and that of the patients entrusted to your care. On going education in infection control will be provided.

3. **Infection control in dentistry is a very serious matter and is receiving the highest priority in the profession today. Therefore, all members of the command must be trained in infection control prior to performing any direct patient care or ancillary functions to patient care.**

I HAVE RECEIVED TRAINING IN INFECTION CONTROL;

I AM RESPONSIBLE FOR UNDERSTANDING THE MATERIAL CONTAINED IN BUMEDINST 6600.10A AND NAVDENCENS DIEGO INST 6600.10C, THE "DENTAL INFECTION CONTROL MANUAL", AND WILL ADHERE TO COMMAND POLICIES SET FORTH THEREIN.

SIGNATURE _____ RANK/RATE/TITLE _____ DATE _____

- WELCOME TO NAVAL DENTAL CENTER, SAN DIEGO! -

BDC Infection Control Officer Signature _____

FORWARD THIS FORM TO THE COMMAND TRAINING OFFICER